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SENATE BILL 2760 By McNally

HOUSE BILL 2707
By Shepard

AN ACT to amend Tennessee Code Annotated, Title 56, relative to recoupment of healthcare provider claims.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56 is amended by adding the following Sections 2 through 10, inclusive as a new chapter:

SECTION 2. As used in this section:

(1) "Covered person" means a person on whose behalf an insurer offering a health benefit plan is obligated to pay benefits or provide services.

(2) "Health insurance coverage" has the same meaning as Tennessee Code Annotated, Section 56-7-109.

(3) "Health insurance entity" has the same meaning as Tennessee Code Annotated, Section 56-7-109.

(4) "Healthcare provider" means any person or entity performing services regulated pursuant to Tennessee Code Annotated, Title 63 or Title 68, Chapter 11.

(5) "Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a health insurance entity retroactively to collect

payments already made to a healthcare provider with respect to a claim by reducing other payments currently owed to the healthcare provider, by withholding or setting off against future payments, by demanding payment back from a healthcare provider for a claim already paid or in any other manner reducing or affecting the future claim payments to the healthcare provider.

SECTION 3.

(a) A managed care entity shall not require a provider to appeal errors in payment where the health insurance entity has not paid the claim according to the contracted rate. Miscalculations in payments made by the health insurance entity shall be corrected and paid within thirty (30) calendar days upon the health insurance entity's receipt of documentation from the healthcare provider verifying the error.

(b) A health insurance entity shall not be required to correct a payment error to a provider if the provider's request for a payment correction is filed more than twelve (12) months after the date that the healthcare provider received payment for the claim from the health insurance entity.

SECTION 4.

(a) Except in cases of fraud committed by the healthcare provider, a health insurance entity may only retroactively deny reimbursements to a provider during the twelve (12) month period after the date that the health insurance entity paid the claim submitted by the healthcare providers.

(b) A health insurance entity that retroactively denies reimbursement to a healthcare provider under this section shall give the healthcare provider a written or electronic statement specifying the basis for the retroactive denial.

(c) If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall specify the name and address of the entity acknowledging responsibility for payment of the denied claim.

(d) If a health insurance entity retroactively denies reimbursement for services as a result of coordination of benefits with another health insurance entity, the healthcare provider shall have twelve (12) months from the date that the healthcare provider received notice of the denial, unless the health insurance entity that retroactively denied reimbursement permits a longer period, to submit a claim for reimbursement for the service to the health insurance entity responsible for payment.

SECTION 5. If a health insurance entity determines that payment was made for services rendered to an individual who was not eligible for coverage, or that payment was made for services not provided by the covered person's health insurance coverage, the health insurance entity shall give written notice to the healthcare provider and:

(1) Request a refund from the healthcare provider; or

(2) Make a recoupment of the overpayment from the healthcare provider in accordance with Section 6 of this act.

Unless the health insurance entity made a representation of eligibility or coverage which was relied on in good faith by the healthcare provider and the services were performed by the healthcare provider.

SECTION 6. If a health insurance entity chooses to collect an overpayment made to a healthcare provider through a recoupment against future healthcare provider payments, the health insurance entity shall, within twelve (12) months from the date that the health insurance entity paid the claim, give the healthcare provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The covered person's name to whom the recoupment applies;

(3) Patient identification number; and

(4) Date of service

SECTION 7.

(1) If the commissioner of commerce and insurance (commissioner) finds a health insurance entity has failed to comply with the provisions of this section, the commissioner may impose a penalty of three (3) times the amount of the claim or five hundred dollars ($500) whichever amount is higher.

(2) In the alternative, the healthcare provider may seek injunctive or other appropriate relief in the chancery court of Davidson County.

SECTION 8. The commissioner shall adopt rules and regulations to ensure compliance with this section within one (1) year of the effective day of this act.

SECTION 9. The provisions of this act shall not be waived, voided or nullified by contract.

SECTION 10. The provisions of this act shall not apply to Tenncare.

SECTION 11. This act shall take effect July 1, 2002, the public welfare requiring it.